DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: November 1, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey and complaint visit was conducted at this facility on October 26, 2011 through November 1, 2011. The census on the first day of the survey was fifty-five (55). The deficiencies contained in this report are based on record review, observation, staff interviews and review of other facility documentation as indicated. The survey sample totaled ten (10) records eight (8) active and two (2) closed with a subsample of seven (7) residents for observations only.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** **§483.10(b)(11) Notification of changes. (i)A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is-**	

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; **(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);** **(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or** **(D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a).** Based on record review and interview it was determined that the facility failed to consult the physician and failed to notify the family representative when there was a significant change in condition for one (R4) out of ten sampled residents. Findings include: The facility's standing order for decubitus ulcer stated: Stage3 or more- notify physician and wound consultant. The decubitus ulcer policy stated: Stage 3 or more- notify wound consultant if ok with family. Review of R4's nurses' note dated 8/18/11 documented R4 developed unstagable bilateral heel pressure ulcers. There was no documentation indicating that the physician was notified until 8/25/11, (7 days later) when the order for wound care protocol was written. A nursing note dated 8/25/11 at 1:00 PM	§483.10(b)(11) The procedure for Pressure Ulcers, Treatment of (Procedure 551) has been updated with a step-by-step guide of the facilities procedure for treating pressure ulcers which includes notifications. A Pressure Ulcers, Check Sheet for (Procedure 553) has also been introduced to provide a visual guide for the nurses. This check sheet is to be initiated for each pressure ulcer and is to be part of the residents permanent record. Both Procedure 551 and 553 address the list of who is to be notified and when the notifications are to occur. At the staff meeting on January 17, 2012, nurses were reminded to notify the physician and family members of any change in status prior to the end of the shift. The check sheet was introduced and discussed along with the policy for Notifications, Physician (Procedure 502). A copy of the following have been provided to all nurses: Pressure Ulcers, Treatment of; Pressure Ulcers, Documentation of; Pressure Ulcers, Check Sheet for; and Notifications, Physician. (See attachment 1). The Infection Control nurse will be responsible to monitor all documentation of pressure ulcers on a monthly basis to ensure compliance.

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	documented R4's POA (power of attorney) agreed to wound care protocol and the doctor was made aware by phone. Interview with E3 (DON) on 11/1/11 at 11:00 AM confirmed that the facility failed to notify the physician and the family on 8/18/11 when the unstagable pressure ulcers were identified. **§483.25(c) Pressure Sores** **Based on the comprehensive Assessment of a resident, the facility must ensure that—** **A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.** **This requirement is not met as evidenced by:** Based on record review, observations and interviews, it was determined that the facility failed to identify pressure ulcers until they became unstagable for one (R4) out of ten sampled residents. The facility also failed to provide care and services to promote wound healing and prevent new sores from developing. R4's assessments of pressure ulcers were not conducted weekly. Findings include: The facility's standing orders stated: 18) Decubitus Care- Stage 3- or more- notify MD (physician) and wound consultant. DON is to be notified the same day of all residents who develop a pressure area. Skin sheet is to be initiated by nurse on the shift that	§483.25(c) The Skin Assessment, Guidelines for (Procedure 602) (see attachment 2) was reviewed at the January 17, 2012 staff meeting. Nursing Assistants were reminded that a total skin assessment is to be done during ADL care on each shift and all abnormalities are to be reported to the nurse. Nurses were reminded to follow the procedure for Pressure Ulcer, Treatment of (Procedure 551) for any pressure ulcer or major skin alteration. (See attachment 1). The Infection Control nurse will be responsible to monitor that skin checks are being done and documented. The Infection Control nurse will be responsible to monitor documentation of pressure ulcers on a monthly basis to ensure compliance with the policies and procedures of pressure ulcers.

Provider's Signature Mark Yoder, Jr. Title Owner Date 2/13/2012

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	discovers the open area. Skin sheet is to be completed weekly at designated weekly skin check. The facility's decubitus ulcer policy stated: Stage 3 or more- Notify wound consultant- if OK with family. Dietary is to be notified Increase nutrition needs until wound healed. Protocol of shake-ups three/times daily, Arginaid twice daily, Vitamin C 1000mg daily, Zinc 220mg daily, Vitamin E 400mg daily until area is healed ... R 4 had diagnoses which included vascular dementia, Alzheimer's, pacemaker, diverticular disease, gastroesophageal, reflux disease, hypertension, constipation, acute cholecystitis, deep vein thrombosis, and cerebral vascular accident history. The weekly skin assessment activated for the month of August for R4 documented on 8/15/11 "clear" indicating that R4 did not have any skin breakdown. A nursing note dated 8/18/11 documented that an "aide and student found unstagable white and black area to heels bilaterally; balmex and moon boots were applied and a pillow was placed under lower legs". There was no documentation indicating the physician, the family or the wound consultant was notified as stated in the facility's Standing Orders. A nursing note dated 8/22/11 documented "Tx (treatment) given to bilateral heels with skin prep & heels to dangle—Areas measured , Lt (left) heel 5cm diameter with white soft slough—Rt (right) heel 4cm diameter with brown to black tissue". The TAR (treatment administration record) noted 8/22/11 "Apply skin prep to bilateral	§483.25(c) The Skin Assessment, Guidelines for (Procedure 602) (see attachment 2) was reviewed at the January 17, 2012 staff meeting. Nursing Assistants were reminded that a total skin assessment is to be done during ADL care on each shift and all abnormalities are to be reported to the nurse. Nurses were reminded to follow the procedure for Pressure Ulcer, Treatment of (Procedure 551) Procedure #1-3 & #5-6 state who is to be notified and # 4 & 9 state the facilities standing orders for nutritional supplements and treatments to be initiated for any pressure ulcer or major skin alteration. The Infection Control nurse will be responsible to monitor that skin checks are being done per policy and accurately documented. The Infection Control nurse will be responsible to monitor documentation on a monthly basis to ensure compliance with Polices & Procedures of Pressure Ulcers.

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	heels 4 times a day". Review of physician orders, standing orders and policy and procedures failed to contain this treatment. On 8/25/11 (seven days later after the pressure ulcers were identified) the physician was notified and an order for "wound care protocol" and dietary orders were written. E3 (DON) also stated she could not find any physician's order to support the 8/22/11 treatment that was used on the TAR until 8/26/11. E19 (wound consultant) initially assessed R4's pressure ulcers on 8/29/11 and documented UTD (unable to determine) due to necrosis and suspected deep tissue injury. Each wound consult visit documented UTD (and with recommendations). On 9/26/11 the right heel was assessed as stage 3 and the left heel was stage 2 that later healed. Review of R4's skin assessment sheet revealed the staff nurses were documenting R4 heel wounds as unstagable on the facility's weekly skin assessment until 8/29/11. From 8/29/11 until 10/17/11 the wound was documented as a stage 2. From 10/17/11 to 10/31/11 R4's skin assessment sheet failed to contain documentation indicating R4's right heel was assessed. There was no wound consult documentation indicating that R4's right heel pressure ulcer was assessed and measured from 10/3/11 until 10/31/11. An interview with E19 (wound consultant) on 10/31/11 at approximately 9:30 AM, revealed that E19 failed to assess R4's wounds because the resident was not in his room, he was involved in activities. E3 (DON) was interviewed on 10/31/11 about E19's lack of assessment of R4's heels for	The Skin Assessment, Guidelines for (Procedure 602) was reviewed at the staff meeting on January 17, 2012. The nurses were reminded that it is their responsibility to assess skin weekly and document findings on the weekly skin assessment form per facility procedure. Open wounds should be assessed daily during treatment for signs of infection, worsening of condition. The Infection Control nurse will be responsible to monitor for compliance monthly. At a meeting with the D.O.N., the Wound Consultant was informed that residents that have been identified with skin integrity issues are to have weekly skin assessments done when visiting the facility per procedure. If a resident is not accessible, the Wound Consultant is to ask the staff on duty for assistance. The staff will bring the resident to the room for the assessment to be completed. The D.O.N. will monitor that weekly assessments for those residents are being done by the Wound Consultant.

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	3 weeks. E3 stated that the staff would have excused R4 from activities and assisted E19 if asked. The care plan documented "altered skin integrity- open area" was initiated on 8/23/11. R4's Total Plan of Patient Care (for CNA use) documented" Moon boots on at all times" and "Heels off –load". R4 was observed not wearing moon boots –in his room on 10/26/11 at 9:35 AM and in a recliner at the nursing station on 10/27/11 at 10:00 AM and 10/31/11 at 9:00 AM. When R4 was brought by wheel chair to E19 and the surveyor on 10/31/11. R4 was wearing only footies. E19 reminded staff to "off load" his heels; leg devices were applied to WC as well as moon boots, which was on the total care plan that all staff view daily. **§483.25(h) Accidents** **The facility must ensure that –** **(1) The resident environment remains as free from accident hazards as is possible; and** **(2) Each resident receives adequate supervision and assistance devices to prevent accidents.** **This requirement is not met as evidenced by:** Based on observation and interview it was determined that the facility failed to ensure residents' side rails were not an accident hazard as a potential head or body part entrapment. Three (SS#6, R6, and SS#7) out of 12 residents (including the subsample) were observed in their beds with unsafe side rails that had a large gap between the mattress and the side rail. Findings include:	The Pressure Ulcer, Treatment of (Procedure 551) #12 was reviewed at the staff meeting on January 17, 2012 which states "Update Nursing Assistant Care Plan and C.N.A. sheets with all treatments that apply to the Nursing Assistant care." The nurses were reminded to update the Care Plan and C.N.A. sheet and to monitor each shift to ensure that the treatments were being followed as documented. The C.N.A.'s were also reminded at the staff meeting on January 17, 2012 to follow the plan of treatment for each resident as specified in the Care Plan and C.N.A. sheets. The Infection Control nurse will complete a weekly QA and report to the D.O.N. of any non-compliance. Each nurse has received a copy of the following policies for their review: Pressure Ulcers, Treatment of (Procedure 551) Pressure Ulcers, Documentation of (Procedure 552) Pressure Ulcers, Check Sheet for (Procedure 553) Skin Assessment, Guidelines for (Procedure 602) A mandatory in-service "Pressure Ulcer Prevention" was held on January 26, 2012 with Teresa Matthews, Family Nurse Practitioner for all nursing staff.

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	On 10/26/11 at 8:45 AM during the initial tour of the facility, three beds that were identical in make and style were identified as having unsafe side rails which allowed a large gap between the mattress and the side rail when the head of the bed was elevated. The gap was observed to become larger with the increase in the elevation of the head of the bed allowing for a potential head or body part entrapment. 1 .SS#6 was observed in bed with two full side rails up and the head of the bed was elevated greater than 75 degrees. One of the full side rails had padding while the other side did not. The side that was not padded allowed a gap between the side rail and the mattress by the head of the bed. 2. R6 was observed in bed with two full side rails up with the head of his bed approximately 75 degrees. The side rail located by the wall had a large gap between the side rail and the mattress when the head of the bed was elevated. 3. SS#7 was observed sitting up in bed eating breakfast with the head of the bed at approximately a 90-degree angle. With the head of the bed elevated, there was a large gap between the side rail and the mattress. On 10/26/11 at 11:20 AM, two surveyors measured the gap between the mattress and side rail of SS#7's bed. The gap between the side rail and the mattress measured to be a 9 ½-inch gap. Upon further investigation it was determined that the gap between the side rail and the mattress would change depending on	§483.25(h) As stated, the 3 beds identified in the deficiencies were removed immediately from the facility and disposed of. Acceptable replacements were put in place. A QA of all beds in the facility was done on 1/30/12 and a schedule was established to replace all full rail beds with low beds. (See attachment #3). The Administrative Assistant will monitor that the schedule is followed and that all beds stay in compliance in the future.

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	where the staff set the side rail bar height. On 10/26/11 at 11:25 AM, review of the surveyor's findings with E3 (DON) confirmed the gap between the three residents' mattresses and side rails were an accident hazard. On 10/26/11 at 1:00 PM review of surveyors findings with E2 (Administrative Assistant) confirmed that the 3 beds mentioned above were the same style of bed and staff could change the setting at anytime allowing for the large gap between the mattress and side rail causing a accident hazard. E2 immediately had the staff remove all three beds from the facility. **§483.70(c)(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.** **This requirement is not met as evidenced by:** Based on observation and interview it was determined that the facility failed to ensure that the oxygen concentrators had filters and the filters were clean for 3 (SS#4, SS#5 and SS#3) subsampled residents. Findings include: On 10/26/11 during the initial tour of the facility three residents (SS#3, SS#4 and SS#5) were observed wearing nasal cannulas that were connected to oxygen concentrators. Upon assessing the oxygen concentrators, one concentrator failed to have a filter and two concentrators had filters that were very dusty. This was observed again on 10/27/11 and 10/28/11. 1. On 10/28/11 at 12:45 PM E16 (LPN)	§483.70(c)(2) Oxygen concentrators are scheduled to have the air filter cleaned every Saturday and is scheduled on the Treatment record for each resident requiring oxygen. Compliance Rounds will be done weekly for 30 days beginning 2/12/12 and any deficiencies will be addressed immediately. After the initial 30 days, a Compliance Round will be done monthly or as needed and the results reported to the Infection Control nurse. A copy of Oxygen Concentrators, Care of - Procedure 516 (see attachment #4) was reviewed at the nursing staff meeting on 1/17/2012 and a copy of this policy was given to each nurse.

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	was shown the missing filter for SS#5 oxygen concentrator. E16 stated she would take care of it. 2. On 10/28/11 at 1:00 PM E17 (LPN) was shown the dusty filter for SS#3, E17 immediately cleaned the filter. 3. On 10/28/11 at 12:45 PM E16 (LPN) was shown the dusty filter for SS#4 oxygen concentrator. Review of the oxygen concentrator filters with E2 (Administrative Assistant) on 10/28/11 at approximately 12:55 PM revealed staff were supposed to clean and check oxygen concentrator filters weekly. On 11/1/11 at approximately 10:00 AM E2 was shown SS#4's oxygen concentrator filter that was still dusty requiring cleaning. **§483.75(e)(8) Regular In-Service Education.** **The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must—** **(i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;** **(ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and** **(iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of**	

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	the cognitively impaired. **This requirement is not met as evidenced by:** Based on CNA. in-service record review and interview, it was determined that the facility failed to ensure that CNA's maintained 12 hours of in-service per year. Findings include: 1. CNA E5, had no in-service hours recorded for the previous year based on anniversary date of hire. 2. E6 had 7 in-service hours recorded for the previous year based on anniversary date of hire. 3. E7 had 6 in-service hours recorded for the previous year based on anniversary date of hire. 4. E8 had 6 in-service hours recorded for the previous year based on anniversary date of hire. 5. E9 had 5 in-service hours recorded for the previous year based on anniversary date of hire. 6. E10 had 5 in-service hours recorded for the previous year based on anniversary date of hire. 7. E11 had 7 in-service hours recorded for the previous year based on anniversary date of hire. 8. E12 had 8 in-service hours recorded for the previous year based on anniversary date of hire. **483.75(o) Quality Assessment and**	§483.75(e)(8) The facility has established a regular in-service program. All staff are required to complete a monthly in-service. Additional in-services will be scheduled based on evaluation reviews, problem areas as a result of QA's , etc. At the end of each month, an audit will be done to ensure all staff have completed the required monthly in-service. Disciplinary action will be taken for any staff who have not completed the requirement. (see attachment #5 for a schedule of required in-services). The Administrative Assistant will monitor monthly to ensure all in-services are completed as scheduled.

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	Assurance **(1) A facility must maintain a quality assessment and assurance committee consisting of –** **(i) The director of nursing services;** **(ii) A physician designated by the facility; and** **(iii) At least 3 other members of the facility's staff.** **(2) The quality assessment and assurance committee –** **(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and** **(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.** **(3) State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.** **(4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.** **Intent: 483.75(o) Quality Assurance and Assessment** **This requirement is not met as evidenced by:** Based on observation, review of documentation and interview it was determined that the facility failed to have an effective Quality Assurance and Assessment program. Findings include: Review of the QA (Quality Assurance) program with E3 (DON) on 1/3/11 at 12:45 PM revealed the facility reviewed incident reports and infection control. Residents	483.75(o) A Quality Assurance Program is currently being developed to meet the Federal Regulations. New manuals for the various departments are being implemented that have a Quality Assurance Program. The facility is also working with Medline to purchase the abaqis program to conduct resident assessments. The goal is to have this program in place by April. The Quality and Assessment committee is scheduled to meet on February 24th. The Administrative Assistant will attend these quarterly meetings and monitor that facility issues are being addressed and plan of actions are being developed and implemented.

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	care plans were developed to address these concerns and meet the individual resident's needs. E3 also stated that when an incident occurred in the facility they took care of it immediately. E3 continued to state that she did not know how to do QA and has not had education nor does she have tools to help her provide an effective proactive Quality Assurance program for the facility. On 1/3/11 at 1:10 PM review of the Quality Assurance program concerns were discussed with E2 (Administrator Assistant) who stated she would work on putting an effective Quality Assurance Committee and program together.	
3201.5.0	**Personnel/Administrative**	
3201.5.1	**The administrator(s) shall be responsible for complying with all applicable laws and regulations.** **This requirement is not met as evidenced by:** Based on record review, interviews, review of other facility documents and observations it was determined that the administrator failed to ensure the facility complied with the applicable laws and regulations. Findings include: 1. Cross refer Title 16, Chapter 11, §1131 (8) Definitions "Mistreatment" The administration failed to ensure all staff members were properly trained and able to provide care in a manner that did not constitute mistreatment of a resident. 2. Cross refer Title 16 Chapter 11, §1121 (6)	3201.5.1 1. The Administrator has been informed and has approved of the training put in place thru in-services to ensure that all staff are properly trained and able to provide care in a manner that does not constitute mistreatment of a resident. In-services will be done yearly and if incidents occur. The Administrator will be informed at the Quality Assurance committee meetings of the status of the in-service program and if any incidents have occurred during the quarter. 2. The Administrator has ensured that privacy curtains have been installed in the old building. He was informed of the QA audit performed on 2/12/12 in regards to the privacy curtains. The Administrator has requested a QA be done monthly to ensure privacy is being given during care. The Administrator will be informed at the quarterly QA meetings of the results of the monthly audit.

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	The administration failed to ensure the residents in the facility were provided privacy during care. The facility also failed to provide privacy concerning the resident's medical information. 3.Cross refer 3201.6.3.7 assessment The administrator failed to ensure residents were assessed at least quarterly. 4. Cross CNA training 3201.5.1 and 3201.6.8.1.1 The administration failed to ensure CNA's had training as required by the regulations. 5. Cross refer pressure ulcer 483.25 (c) The administration failed to ensure a resident with a pressure ulcer received the appropriate care and service. 6. Cross refer accident hazard 483.25 (h) The administration failed to ensure resident's beds side rails fit properly to prevent accident hazards. 7. Cross refer 3201.6.8.1.1 The administration failed to ensure only licensed staff provided oxygen to a resident. A Resident received oxygen provided by a CNA and not a licensed staff member. The resident was not assessed for the need of the oxygen by a licensed staff member.	2. a. The Administrator approved of the plan to remove the residents care plan from the wall to the front of the CNA book to ensure privacy in regards to the residents medical information. He has requested that the DON monitor that this plan is followed in the future. 3. The Administrator is aware of the quarterly assessment form that has been implemented. He has requested a monthly QA to be done by the Ward Clerk to ensure that all monthly and yearly assessments are being done. The Administrator will be informed at the quarterly QA meetings of the results of the monthly audit. 4. The Administrator is aware of the in-service program that is currently in place. he has been informed that January's in-service has been completed by all staff. The Administrator has requested that a quarterly report of the monthly audits be given at the QA meeting. 5. The Administrator attended the nursing staff meeting on 1/17/12 in which the nurses were in-serviced on the policy and procedure for pressure ulcers. He has requested that the Infection Control nurse monitor and report to the DON of any compliance issues in regards to pressure ulcers. 6. The Administrator was informed of the side rail issues with 3 of the facilities beds. He has requested that the facility begin to purchase low beds to replace the beds with full side rails. The audit of the facilities beds performed on 1/30/12 was reviewed with the Administrator and the time line to purchase low beds was approved. The Administrator requested the Administrative Assistant monitor and ensure that the schedule is followed and that all beds remain in compliance. 7. The Administrator has approved the policy for Oxygen Administration - Procedure 515 and was in attendance when this was discussed with the nursing staff at the meeting on 1/117/12. He has requested that the DON inform him of any deviation from the policy.
3201.6.3	**Nursing Administration**	
3201.6.3.1.4	**Coordinate orientation programs for new nursing services direct caregivers (including temporary staff) and in-service education, as appropriate, for such staff. Written records of the content of each in-service program and the attendance records shall be**	3201.6.3.1.4 In-service records are now being kept and reviewed by the Administrative Assistant. The content of each in-service along with the post-test and attendance record is being kept in the Administrative Assistant office. A summary sheet form (see attachment #6) is kept for each employee and a monthly audit is being conducted to ensure the in-service program stays in compliance.

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	maintained for two years. **This requirement is not met as evidenced by:** Based on CNA in-service record review and interview with E4 on 10/27/11, it was determined that the facility failed to maintain written records of the content of in-service programs and the attendance for such. Findings include: The CNA in-service records were kept in summary sheet form. The date, topic and duration of the in-services were retained. No other paperwork was retained from past in-services.	
3201.6.3.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.** **This requirement is not met as evidenced by:** Based on clinical record review and interview it was determined that the facility failed to perform quarterly resident assessments for nine (R1, R2. R3, R4, R5, R6, R7, R8 and R9) out of 10 sampled residents. The facility also failed to develop and review and revise care plans for three (R4, R1 and R5) out of 10 sampled residents. Findings include: 1. Review of R1, R2. R3, R4, R5, R6, R7, R8 and R9's clinical records revealed	3201.6.3.7 A quarterly assessment form has been initiated (see attachment #7). To date, quarterly assessments for all residents have been completed. A schedule for quarterly assessments has been implemented and the Ward Clerk will perform a monthly audit and report any discrepancies to the D.O.N. The D.O.N. will review all assessments and monitor for compliance.

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	there were no quarterly assessments completed for these residents. An interview completed on 10/28/11 at 10:00 AM with the E3 (DON) confirmed the facility failed to perform quarterly assessments as required for the residents in the facility that included the nine above-mentioned residents. 2. A R1 had a PEG (percutaneous endoscopic gastrostomy) tube placement in 11/2010. The Peg tube was discontinued on 7/28/11. A care plan for 'resident receiving bolus feeding' was initiated. An active care plan for "alteration in skin integrity- excoriation of skin folds (9/14/10)" documented on excoriation around the peg tube site on 7/12/11 and 9/13/11. However the facility failed to develop a care plan addressing R1's Peg site/ wound. R1 started having significant complications with the Peg site wound 6/2011. The facility failed to develop a care plan with approaches/interventions for R1's peg site wound b. R1 sustained a significant injury from a 10/10/11 fall, after refusing staff assistance, which resulted in a right lip and eye laceration, suture repair and follow up care with an orthopedic specialist for shoulder rotation cuff tear. Review of R1's care plan revealed the facility failed to develop a plan of care for falls that included approaches and interventions to prevent injury. E17 (LPN) was interviewed on 10/31/11 at approximately 10:40 AM E17 confirmed that the facility failed to develop care plans for R1's peg tube site/abdominal wound and falls. E17 continued to state that the	The D.O.N. will monitor all new doctor orders on a daily basis for any significant changes in physical or mental status of residents. The D.O.N. will monitor that care plans are developed and updated as needed. b. A care plan has been developed for "prevention of falls" for R1. (see attachment #8). In the future, the D.O.N. will monitor that care plans are developed for any resident with a significant change in physical or mental status.

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	DON writes the care plans not the staff nurses. Interview with E3 (DON) on 10/31/11 at approximately 2:00 PM confirmed E17's statement. 3. Cross Refer §483.25(c) Pressure Sores R4 had a pressure ulcer that was first noted in a Nursing note dated 8/18/11 documented R4 acquired unstagable white and black area to heels bilaterally. R4 had physician orders dated 8/25/11 documented wound care protocol that included dietary supplements. The CNA total plan of patient care sheet documented "moon boots at all times". The care plan documented altered skin integrity- "open areas to both heels" was initiated 8/23/11. The care plan failed to be reviewed and revised to include the dietary supplements as ordered by the physician and the "moon boots at all times" as indicated by CNA's (total plan of patient care) sheet. Interview with E17 (LPN) on 11/1/11 at approximately 11 AM confirmed that the facility failed to revise the care plan to include the previously mentioned approaches. 4. Cross refer 6.8.1.8 R5 had an order for oxygen as needed to keep her oxygen saturation above 92%. Review of R5's care plans revealed the facility failed to develop a care plan for R5's respiratory problems that required the use of oxygen. Review of R5's care plans with E3 (DON) on 10/31/11 at 10:45 AM confirmed that	3. The policy and procedure manual is currently being updated and all new policies will include a care plan documentation guideline section to ensure that all areas are being addressed on the care plan. (see attachment #1 pg 2) The D.O.N. will use this section as a guideline when reviewing and revising the care plan and in the future will monitor that the care plans include all approaches of the resident care. 4. At the nursing staff meeting on 1/17/12, the nurses were reminded that the care plan is to be updated when problems occur or when they are resolved. They were reminded that the care plan needs to be updated promptly by either the nurse or the D.O.N. The D.O.N. is to be made aware of any revisions to the care plan or any revisions that need to be made. The D.O.N. will also monitor all new doctor orders to ensure that the care plans are being updated promptly.

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	R5 should have had a care plan that addressed her respiratory problems that required the use of oxygen. The facility's Interdisciplinary Care Plan policy states in paragraph 1 under Objective- update when problems occur or are resolved, reviewed at care plan meeting every 60 days. Paragraph 6 states Change in Condition- changes in resident should be addressed via the care plan promptly. They can be addressed by DON, nurses. Examples include but are not limited to: 1. New pressure sores or other skin conditions.	
3201.6.8	**Medications**	
3201.6.8.1	**Medication Administration**	
3201.6.8.1.1	**All medications (prescription and over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days.** **This requirement is not met as evidenced by:** Based on clinical record review and interview it was determined that the facility failed to have a diagnoses for the use of Lasix for one (R5) out of 10 sampled residents. Findings include: R5 was admitted to the facility with diagnoses that included insulin dependent	3201.6.8.1.1 All resident charts have been updated with supporting diagnosis for medications. It was reviewed at the nursing staff meeting on 1/17/12 that when a new order for medication is written, it must have a diagnosis to support it. The diagnosis is to be written on the doctor order when sending it to the physician and pharmacy. The D.O.N. will audit the Physician Orders when they are received monthly from the pharmacy to ensure all medications have supporting diagnosis listed.

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	diabetes mellitus, dementia, anxiety, agitation, organic mental syndrome with agitation, deep vein thrombosis, bronchospasms and gastroesphogeal reflux disease. Review of R5's physician order on the September 2011 physician order sheet revealed an order for Lasix 40 mg one tablet by mouth twice daily. There was no diagnosis for the use of the Lasix in the chart. Review of R5's chart with E17 (LPN) and E3 (DON) on 10/31/11 at 9:40 AM confirmed there was no supporting diagnosis for the use of the Lasix.	
3201.6.8.1.8	**Only licensed nurses shall administer medications and then record the administration on the resident's Medication Administration Record (MAR) immediately after administration to that resident.** **This requirement is not met as evidenced by:** Based on clinical record review and interview it was determined that the facility failed to have a licensed nurse assess and administer oxygen to one (R5) out of 10 sampled residents. Findings include: "Oxygen-A medicinal gas used in the management of anemia, ..." (Taber's Cyclopedia Medical Dictionary Edition 19.) R5 was admitted to the facility with diagnoses that included insulin dependent diabetes mellitus, dementia, anxiety, agitation, organic mental syndrome with agitation, deep vein thrombosis, bronchospasms and gastroesphogeal	

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	reflux disease. Review of R5's physician orders revealed an order originated on 4/6/11: -"O2 at 2liters per minute via nasal cannula as needed to keep O2 Saturation greater than 92 percent. -Check O2 Saturation every shift. --Albuterol sulfate 2.5 mg/ml vial-neb one vial via nebulizer every day at 7 am and every four hours as needed." R5's nurses' notes dated 7/25/11stated 6:00 AM "4:30 AM CNA reported while taking SPO2 (saturation) that she just applied O2 at 2 liters/minute via nasal cannula due to resident being restless most of the night SpO2 98% resting comfortably." There was no documentation indicating a nursing assessment was completed prior to the administration of the oxygen. Review of R5's clinical record with E3 (DON) on 10/31/11 at 10:45 AM confirmed that oxygen is considered a medication and should not have been administered by the CNA. The oxygen was to be administered if R5's O2 saturation was low not for behavioral issues. The nurse should have assessed the resident and administered the oxygen as ordered by the physician.	3201.6.8.1.8 The policy for Oxygen Administration - Procedure 515 (see attachment #9) was given to each nurse and it was discussed at the nurses staff meeting on 1/17/12 that only nurses are to administer oxygen. Each nurse will monitor the resident receiving oxygen on their wing and report and deviations from the policy to the D.O.N. for further disciplinary action.
3201.6.9.6	**The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.** **This requirement is not met as evidenced by:** Based on observations throughout the facility during the survey, it was	

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	determined that entire facility was not free of live insects. Findings include: Multiple flies were observed in multiple areas throughout the survey. This included the kitchen, resident rooms and common areas. Residents without the ability to shoo flies were observed with flies crawling on them. Additionally, the residents meal plates observed during meals also were found with flies.	3201.6.9.6 The facility has a contract with Reilly's Pest Control to help eliminate unwanted pest. The summer of 2011, Mr. Reilly was coming to the facility every other week and treating the interior and exterior for flies. Multiple fly lights have been placed thru out the building. After the recent survey, it was requested that Mr. Reilly present us with a plan of correction for the upcoming year. Please see attachment #10 for his plan of correction. The Administrative Assistant will monitor during the summer months the effectiveness of the plan and if not effective help to implement more changes.
3201.6.10.1.4 .5	**Monitor the rate of nosocomial infection** **This requirement is not met as evidenced by:** Based on review of the infection control records and interview with E3, D.O.N., it was determined that the facility failed to monitor the rate of nosocomial infections. Findings include: Over a 6 month period from the beginning of April 2011 to the end of September 2011, only 18 out of 65 infections that were tracked lacked an indication of whether the infection was nosocomial or community acquired. This data was captured anecdotally with no infection rates calculated or reviewed.	3201.6.10.1.4.5 An Infection Prevention Manual was purchased and is the process of being tailored to our facility. The manual included a CD that had forms available as an Excel spreadsheet for calculating infection rates. The manual also included forms to track whether the infection was nosocomial or community acquired. These forms (see attachment #11) are being implemented along with the position of an Infection Control nurse who will maintain records of all nosocomial infections and corrective actions along with providing in-service to staff as practices are observed and corrections or changes in practice are needed. The Infection Control nurse will be responsible to provide documentation as to the infection control program to the committee at the quarterly meetings.
3201.6.10.1.5	**The infection control coordinator shall maintain records of all nosocomial infections and corrective actions related to those infections to enable the committee to analyze clusters or significant increases in the rate of infection and to make recommendations for the prevention and control of additional cases.** **This requirement is not met as evidenced by:**	

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	Based on review of the infection control records and interview with E3, D.O.N., it was determined that the facility failed to maintain records of corrective actions related to nosocomial infections. Findings include: Interview on 10/31/11 at 10:20AM, with E3, D.O.N., indicated that no records were available for in-service or training based on infection control issues.	3201.6.10.1.5 An Infection Control in-service has been scheduled for December in the yearly list of in-services. The in-service for Prevention and Treatment of Urinary Tract Infections is also scheduled for May. (see attachment #12) The Administrative Assistant will conduct an audit at the end of the month the in-services are scheduled to ensure compliance for all staff. The Infection Control nurse will conduct one-on-one training with personnel as practices are observed and corrections or changes in practice are needed. A report will be given at the quarterly Infection Control meetings of any issues that need to be addressed.
3201.7.3.1.3	**Hot water accessible to residents shall not exceed 110° F.** **This requirement is not met as evidenced by:** Based on hot water temperature readings taken in the resident rooms, it was determined that the facility failed to maintain hot water at or below 110° F for the safety of the residents. Findings include: 1. On 10/26/11 at 11:25 AM, the hot water temperature of room #115 was recorded at 115° F. 2. On 10/26/11 at 11:33 AM, the hot water temperature of room #112 was recorded at 113° F.	3201.7.3.1.3 The hot water heater was adjusted to meet the requirements of the 110 F regulation. The Administrative Assistant will conduct a quarterly audit and report to the Quality Assurance committee the finding of the audit for further action if necessary.
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code** **Delaware Food Code 2009** **3-301.11 (B) Except when washing fruits and vegetables as specified under § 3-302.15 or as specified in ¶ (D) of this section, food employee may not contact**	3201.7.5 At the 1/17/12 nursing staff meeting, the staff were reminded to use a glove or a utensil when handling residents food. The Food Service Manager will monitor when doing monthly audits of the dining room and report any deficiencies to the Administrative Assistant. The D.O.N. and Administrative Assistant will monitor sporadically to ensure compliance.

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	exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. **This requirement is not met as evidenced by:** Based on dining observation in the main dining room on 10/25/11, it was determined that staff failed to utilize utensils or barriers when handling ready-to-eat food. Findings include: E13, LPN, was assisting R2 (Administrative Assistant) with his lunch meal. This resident was non-compliant with sitting and eating at a table place setting. While attempting to feed this resident, food dropped off of the plate and on to the tray underneath. This food was pushed onto a spoon with E13's bare hand and returned to the plate. This food was later fed to the resident.	
3201.7.6.3	**For on-site laundry processing, the facility shall:**	
3201.7.6.3.1	**Provide a room under negative air pressure for receiving, sorting, and washing soiled linen.** **This requirement is not met as evidenced by:** Based on observation of the clean and soiled linen areas on 10/27/11, it was determined that the facility failed to provide a room under negative pressure for soiled linen processing. Findings include: The windows of both the soiled and clean linen room were open with screens in	3201.7.6.3.1 Laundry staff have been in-serviced that the windows are to remain closed and the door between the soiled and clean linen room is to remain closed at all times. The motor on the ventilation fan was replaced and the laundry staff have been informed that it is to remain on during working hours. The Administrative Assistant will perform monthly audits to ensure the regulation is being followed.

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	place. The door between the rooms was open. There was no discernable negative air flow in the soiled linen room.	
3201.8.0	**Emergency Preparedness**	3201.8.2
3201.8.2	**Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills.** **This requirement is not met as evidenced by:** Based on review of the fire drill records and follow-up survey with E2 (Administrative Assistant) on 10/27/11, it was determined that the facility failed to conduct fire drills at least quarterly on each shift. Findings include: No drill was conducted on the first shift of staff (6AM to 2PM) for the third quarter of 2011.	The facility is now current with the quarterly fire drills. The drills are now scheduled a year in advance to ensure that all drills are completed on time. The Administrative Assistant will monitor that the drills are completed as scheduled and will report quarterly to the Quality Assurance committee the dates of the drills that have been done and when the next ones are due.
16 Del. C., Chapter 11, §1121 (1)	**Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement is not met as evidenced by:** Based on dining observations in the main dining room and the Rose Garden unit on 10/26/11, it was determined that staff failed to promote care for R11, R6 and SS#2 in a manner that maintained dignity. Findings include:	

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	The facility's policy and procedure for Serving Food stated Procedure 2. Check name on dietary card on tray and take tray to corresponding patient. The trays of independent patients are to be served first, then the trays of hand-fed patients are removed from the food cart as patients are fed. 1. E15, LPN, was assisting R11 with his lunch, standing over him while assisting. E14, LPN, was in the dining room during the lunch meal to assist various residents with their meals. E14 took over assisting R11 from E15. E14 stood over him while feeding him. 2. On 10/26/11 at 11:35 AM, a dining observation was completed in the Rose Garden unit. In the center of the room was a table with six residents sitting at it. Two of the residents were observed feeding themselves. Two residents were observed being assisted with feeding by E18 (CNA). Two other residents (R6 and SS#2) were observed sitting at the table with their food sitting in front of them. At 11:56 AM after finishing feeding two residents E18 began to feed R6. E16 (LPN) completed her medication pass and began to feed SS#2. Both residents sat at the table while other residents ate for twenty minutes before they were assisted with eating. Review of the facility's policy and procedure revealed it failed to ensure dignity would be provided for residents in the facility. Dining observations were presented on 11/1/11 at 3:00 PM with E1 (Administrator), E2 (Administrator Assistant) and E3 (DON).	16 Del. C., Chapter 11, §1121 (1) 1. The in-service "Helping Alzheimer's elders with eating: Techniques that work" has been scheduled for all staff for the month of February. (see attachment #13) This in-service addresses the deficiency of standing while assisting a resident to eat. The Food Service Manager will perform monthly audits during meal times to monitor that staff are seated while feeding residents and report any problems to the Administrative Assistant. 2. The policy for Eating Support - Procedure 355 (see attachment #14) has been updated to address the issue of feeding residents at the same time. This policy was reviewed with the staff at the nursing staff meeting on 1/17/12. The nurse on each wing will be responsible to monitor the dining room for compliance. The Food Service Manager will conduct monthly audits and report finding to the Administrative Assistant.

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16 Del. C., Chapter 11, §1121 (6)	This is a repeat deficiency from the 11/12/2010 survey. **Each patient and resident shall receive respect and privacy in the patient's or resident's own medical care program. Case discussion, consultation, examination and treatment shall be confidential, and shall be conducted discreetly. In the patient's discretion, persons not directly involved in the patient's care shall not be permitted to be present during such discussions, consultations, examinations or treatment, except with the consent of the patient or resident. Personal and medical records shall be treated confidentially, and shall not be made public without the consent of the patient or resident, except such records as are needed for a patient's transfer to another health care institution or as required by law or third party payment contract. No personal or medical records shall be released to any person inside or outside the facility who has no demonstrable need for such records.** **This requirement is not met as evidenced by:** Based on observation and interview it was determined that the facility failed to ensure privacy was provided for residents in the facility. Findings include: 1. On 10/27/11 at approximately 9:55 AM SS#2 was observed in bed being bathed by E20 (CNA). Two staff members were observed entering the room during the bath that included another CNA and a staff member delivering laundry. A portable bi-fold privacy screen (intended for providing privacy during bathing and care for a resident) was used. With the screen set	16 Del. C., Chapter 11, §1121 (6) 1. Privacy curtains have been installed in the Rose Garden unit in place of the portable bi-fold privacy screen. The majority of the vertical blinds have been replaced with horizontal blinds. The Administrative Assistant will also conduct quarterly audits to ensure the privacy curtains and window blinds remain in good working order and that staff are providing residents with privacy during care.

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	up by SS#2's bed it failed to cover areas large enough to provide privacy for SS#2 during her care. Review of the screen with E20 revealed the screen was missing one of the two curtains it was suppose to have to provide privacy. It was also noted that the vertical blinds located on the large windows were pulled shut. However, there were four slates missing from the vertical blinds allowing anyone passing outside the window view of SS#2's bath. 2. On 10/27/11 at 10:10 AM after knocking on the door and entering the room of R6 it was observed that R6 was being bathed by E22 (CNA Hospice). R6 did not have any clothes on. E22 failed to cover R6 after removing his clothes during the bath. When surveyor asked E22 about the workable tri-fold privacy screen located in the hallway near R6's room E22 stated she did not like to use the tri-fold privacy screen. The facility failed to provide privacy for R6 during his AM care. Review of the equipment with E23 (Maintenance) at 10:30 AM on 10/27/11 confirmed the malfunction of the equipment causing the facility to fail to provide privacy for SS#2 during her am care. E23 stated they were measuring the rooms and ordering privacy curtains today. This was also reviewed with the E2 (Administrator Assistant). 3. During the initial tour of the facility on 10/26/11 it was observed that residents in the facility had their "total plan of patient care" (CNA sheet documenting care to be provided) printed out and taped on the wall of the residents' rooms. The total plan of patient care gave instructions for care that included if the resident was a "feeder",	2. At the nursing staff meeting on 1/17/12, the staff were reminded that the privacy curtains and window blinds are to be drawn at all times during resident care. An in-service "Maintaining respect and dignity: An important part of the caregiver occupation" (see attachment #15) is scheduled for nursing staff in March in addition to the in-service on privacy and dignity scheduled for October. The Administrative Assistant will make the in-service available March 1st and monitor that all nursing staff have completed the in-service by March 31st. The Administrative Assistant will perform monthly audits during resident care to ensure that privacy is being provided. The results of the audit will be reported to the Quality Assurance committee. 3. The "total plan of patient care" for each resident was removed from the residents rooms and placed in the C.N.A book in front of each residents CNA sheet. The staff were informed at the nursing staff meeting on 1/17/12 were to find the care plan and that the care plans are not to be posted in the residents rooms because of privacy concerns. The D.O.N. will monitor and ensure that CNA care plans are kept in the CNA book and not in the residents rooms.

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	"incontinent" or "speech inappropriate" or statements for "check resident through shift for bm (bowel movement) in brief" R7 had a written paper on wall over her bed that stated "R7 place on toilet daily after dinner to prevent constipation" etc. On 10/28/11 at approximately 3:00 PM an interview was conducted with E1 (Administrator) who confirmed that the residents' total plan of patient care sheet with resident information was a breech of privacy for the residents. The residents' total plan of patient care was immediately removed from the walls.	
16 Del. C., Chapter 11, §1131 (8) definitions	**"Mistreatment" shall include the inappropriate use of medications, isolation, or physical or chemical restraints on or of a patient or resident. This requirement is not met as evidenced by:** Based on interview and review of the facility's documentation it was determined that the facility failed to prevent mistreatment to one (R3) out of 10 sampled residents. R3 was physically restrained and removed from the activity area causing a bruise to her right upper arm and small skin tear. Findings include: R3 was admitted to the facility with diagnoses that included Alzheimers, dementia with associated behaviors that cause distress and danger to self or others, mood disorder, psychotic disorder, and symptomatic anxiety. Review of R3's nurses' notes revealed on 11/17/10 a skin assessment was completed, a bruise 6x6 was noted on the right upper arm, skin tear 1 cm x 1 cm was noted on right upper arm."	16 Del. C., Chapter 11, §1131 (8) 16 Del. C., The activity staff have also been informed that they are to ask for help from a nurse or CNA if help is needed in redirecting a resident. The facility will provide staff with in-services on abuse and neglect and how to handle residents with Alzheimer/Dementia on a yearly basis and on an individual basis as needed. The Administrative Assistant will monitor that these in-services are available and provided as needed and will conduct an audit ensuring that all staff complete the in-service when offered.

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	Review of the facilities incident/accident report dated 11/17/10 for skin assessment documented: "Bruise skin tear 1 x 1 right upper arm". An investigation completed by E3 (DON) revealed a statement typed and signed by the DON that stated, "Found bruise 6 by 6 cm and a 1 cm skin tear on right upper arm of unknown origin. On investigation found that the day before resident had been in the activity room during an activity time and was getting in another residents space. The other resident was starting to get agitated. Fearing that he would do something to R3 E24 (Activity Director) attempted to get her out of the area quickly. She said that she turned her to head her out of the area as R3 was resisting and that may have caused the bruising." Review of the above mentioned incident with E1 (Administrator) and E2 (Administrator Assistant) on 11/1/11 at 10:20 AM revealed E24 (Activity Director) was hired about a month prior to the incident. E1 and E2 stated that E24 lacked the education she required on how to handle difficult residents or residents with dementia. Review of the 11/17/10 incident with E24 (Activity Director) on 11/1/11 at 12:05 PM revealed R3 was agitating a male resident. E24 could not get R3 to leave the male resident alone. R3 was confused and believed the male resident was her dead husband. E24 stated that she stood behind R3 wrapped her arms around her, lifted her off the floor and forcibly removed her from the activity room. This action may have caused the bruise and skin tear to R3's upper arm. E24 continued to state that she reacted and should have thought	

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	more before acting. After the incident, E24 stated E3 (DON) told her she acted inappropriately in this situation. E24 continued to state that the facility did not provide her with formal training on abuse and neglect or how to handle residents with dementia before or after the incident.	